STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155729	A. BUILDING 01 B. WING	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HERITAGE	12011 WHITTERN RD MONROEVILLE, IN 46773

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/16/13 Facility Number: 002549 Provider Number: 155729 AIM Number: 200289420 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Adams Heritage was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, in areas open to corridor and hard wired smoke detectors in the resident rooms. The facility has a capacity of 61	K010000	Preparation and execution of this plan of correction does not constitute admission or agreement by provider to the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. adams-Heritage maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, adams-Heritage asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of September 27, 2013. adams-Heritage requests desk review (paper compliance) in lieu of resurvey, if appropriate. Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated accomplished corrective action. These do not	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	and had a census of 55 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinklered except a detached shed used for storage of maintenance equipment, parts and the facility's bus and a detached shed used for storage of maintenance supplies. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/17/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:		necessarily chronologically correspond to the date that Adams Heritage is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	

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K010047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation, record review and interview; the facility failed to ensure a continuously illuminated exit sign, where the exit or way to reach the exit was not apparent, was immediately visible for 1 of 4 ways to the exit. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect residents in 1 of 5 smoke compartments. Findings include: Based on an observation with the Environmental Services Supervisor on 09/16/13 at 1:35 p.m., there was no illuminated exit sign above the fire doors leading to the Occupational Therapy hall from the nurses' station. Based on review of the facilities Evacuation map mounted on the wall at the nurses' station, the Occupational Therapy hall is used for a secondary exit from the center smoke compartment. This was acknowledged by the Environmental Services Supervisor at the time of observation.	K010047	It is the policy of this provider to assure that exit signsare appropirately placed. 1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice? Exit signs were placed above the double doors between Therapy Department and Nursing Station. Exit Signs were placed on both sides of door. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Other residents that could be affected by the same deficient practice would be identified as those without secondary exit signs. None were so identified. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? Exit Signs are permanently fixed to the building. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Monitoring is unnecessary as Exit Signs are permanently fixed to the building. 5. By what date the systemic changes will be completed? September 25, 2013.	09/27/2013

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	3.1-19(b)			

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K010052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 main fire alarm panels located in an area that was not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice could affect all occupants. Findings include: Based on observation with the Environmental Services Supervisor on 09/16/13 at 12:50 p.m., the main fire alarm panel located inside the mechanical room at the nurses' station was not electrically supervised by a smoke detector or in an area continuously occupied. Based on an interview with the Environmental Services Supervisor at the time of observation, the facility has a new	K010052	It is the policy of this provider to assure that appropriate areas are supervised by automatic smoke detectors. 1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice? Automatic smoke detector was installed in the Mechanical Room where the control unit is located. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Automatic smoke detector was installed in the Mechanical Room where the control unit is located. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? Smoke detectors are permanently fixed to the building. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Monitoring is unnecessary as smoke detectors are permanently fixed to the building. 5. By what date the systemic changes will be completed? September 19,	09/19/2013

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	fire alarm panel and replaced the old fire alarm panel which was located at the nurses' station. 3.1-19(b)		2013.	